

# BGA LEGISLATIVE UPDATE



BLACK, GOULD & ASSOCIATES, INC.

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## Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008, passed by Congress in October 2008, promotes equitable care for mental health illnesses by requiring parity between medical and mental health benefits. The law applies to group health plans, including both fully insured and self-funded plans. However, small employers with 2-50 employees and individual coverage are exempt.

The new law was implemented on October 3, 2009 and plan sponsors need to be in compliance beginning with their first plan year renewal after that date.

For health plans that offer medical benefits and mental health and/or substance abuse benefits, the new law has the following impact:

- ◆ Eliminates more restrictive financial requirements, such as co-pays or deductibles, for mental health/substance abuse benefits than are applied to medical/surgical benefits
- ◆ Eliminates more restrictive treatment limitations, such as day or visit limits, for mental health/substance abuse benefits than are applied to medical/surgical benefits

Please be aware that in states with stronger parity requirements, the state law will continue to apply and may, for example, mandate mental health/substance abuse coverage or particular mental health or substance abuse benefits.

Please also note that the regulations under the new law have not yet been issued, and are now expected in January of 2010.

## The New GINA Rules

HHS, IRS and the Department of Labor jointly released final interim rules for the Genetic Information Nondiscrimination Act (GINA). The law was enacted in May 2008 to encourage people to participate in genetic testing, which can help detect and prevent certain illnesses. The law also ensures that genetic information isn't used adversely by health insurers to underwrite plans or deny coverage. But according to Health Plan Week the very broad definitions of "genetic information" and "underwriting" included in the rules will have a profound effect on health risk assessments (HRAs) and their potential value in finding and helping enrollees who have potential health risks. The rules, (which were expected last May), will affect health plans with a plan year that begins on or after December 7, 2009. For health plans that follow a calendar year, the rules go into effect January 1, 2010.

While HRAs typically don't require genetic testing, they often do request information about the enrollee's family medical history. But such information, under GINA, falls under the umbrella of genetic information. The regulations prohibit the collection of such information prior to enrollment in a health plan. Although health plans and employers can request genetic information after enrollment, the requests must to be voluntary, and participants cannot be offered a financial incentive for disclosing such information.

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### New GINA Rules (continued from page 1)

Offering a financial incentive (e.g., cash bonuses or reduced premiums) is considered underwriting and is not allowed under GINA if the HRA includes questions about family medical history.

Family medical history questions are typically asked so that health plans can identify individuals who might be at risk for certain conditions and encourage them to do things to help minimize that risk (e.g., recommending a colonoscopy before age 50 for someone whose father was diagnosed with colon cancer).

### Most Risk Assessments Must Be Revamped.

Health plans and employers will be able to offer financial incentives if they “scrub out” requests for genetic information, including family medical history. Or, they can request such information if there are no financial incentives for providing such information and the individual understands that the information request is voluntary.

## Michelle’s Law HR-2851

Seriously ill college students, covered as dependents, can continue their coverage for up to one year if a doctor orders a medically necessary leave of absence, as mandated by Michelle’s Law.

The law, signed by President Bush on October 8, 2008, applies to both group and individual health plans effective October 9, 2009. Group health plans with a calendar year plan must comply starting January 1, 2010. In addition, self-funded groups are required to comply, unless they opt out of coverage required by Michelle’s Law.

Health plans are required to keep the dependent’s coverage active during a medically necessary leave of absence until:

- ◆ One year after the first date of the medically necessary leave of absence, or
- ◆ The date coverage would otherwise terminate under the plan

In addition to these requirements, three additional criteria must be met:

- ◆ Physician Certification—Written certification from the treating physician that the dependent has a serious illness and/or injury requiring a medically necessary leave of absence.
- ◆ Notice—the health plan must provide a notice describing the terms of maintaining their coverage and the notice must be written in a way that a typical covered person would find understandable. Further, the notice will be included with any notice regarding a requirement for certification of student status under the health plan.